TESTIMONY BEFORE THE HOUSE ENERGY AND COMMERCE COMMITTEE ON HR 5613
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Thank you for the opportunity to testify today on behalf of state Medicaid directors regarding HR 5613. My name is Barbara Coulter Edwards, and I am Interim Director of the National Association of State Medicaid Directors, an affiliate of the American Public Human Services Association. NASMD represents the directors of the 50 state Medicaid programs, plus the Medicaid programs administered by the District of Columbia and the U.S. territories.

Medicaid provides comprehensive health coverage to 62 million U.S. citizens, including on average 1 out of every 3 children in the nation. Medicaid is the largest payer for long-term care services and provides long term care supports in community-based and in-home settings, as well as in nursing homes, for millions of senior citizens and adults and children with disabling conditions. Medicaid is the largest insurer of non-aged adults with disabilities, is often a source of support for people with disabilities who can return to the work force, and plays an increasingly important role in offering coverage to low income working Americans, especially parents, as coverage in the employer sector declines. Medicaid is also relied upon to fill the holes in the Medicare program for low income seniors and people with disabilities: 40% percent of all the spending in the

Medicaid program is for the approximately 14 percent of the enrolled population who is already insured by Medicare.

Medicaid in the states is a program under considerable stress. The major source of that stress is a slowing economy. When state economies slow, people lose jobs, state tax revenues decline -- and the demand for Medicaid services increases. Because states must balance their budgets every fiscal year, slowing tax revenues and increased demand for public services often triggers efforts by states to reduce Medicaid spending. Unfortunately, cuts to Medicaid are difficult to achieve in the timeframe of a single fiscal year. The rate of growth in the program is already lower on a per person basis that the commercial marketplace, so additional cuts to reimbursement run the risk of reducing access or quality of care. Because states must give up the federal revenue that comes with state Medicaid spending, it requires reducing health care spending by $2.40 to achieve a $1.00 reduction in state spending (in a state with a 60% federal matching rate). In addition, because cuts in spending on health care do not reduce the covered population's need for health care, someone else in the system ends up absorbing the cost of unreimbursed care, or individuals who are denied care eventually end up in emergency rooms, often resulting in higher cost and poorer outcomes. While states remained engaged in implementing larger system reforms (e.g., developing health information technology-supported strategies to reduce error and increase information sharing; using managed care to improve access to appropriate services and reduce unnecessary care; and increasing efforts to avoid fraud and abuse), many of these changes require up-front

investments that are difficult to make in the midst of an economic downturn and have return-on-investment cycles in excess of twelve months.

A second source of stress for states is the recent, dramatic change in federal policy as expressed in a series of proposed and enacted federal Medicaid regulations. The Center for Medicare and Medicaid Services (CMS) has issued at least 15 proposed regulations over the last two years (10 in the last six months alone!). Some of the regulations provide guidance for the implementation of major new provisions contained in the Deficit Reduction Act of 2005 (e.g., Section 1915i, use of benchmark benefit plans, cash and counseling, cost sharing, etc.). Others attempt to provide clarification regarding long-standing but perhaps inconsistently applied federal policy. Still others, however, propose to make significant changes in long-standing federal policy, changes that states believe will significantly interfere with achieving the legitimate purposes of the Medicaid program.

Eight of the 17 sets of regulations have been flagged by states as causing potential significant harm to the ability of states to appropriately serve the Medicaid population. This collection of regulations impacts a broad range of Medicaid services and activities, including reimbursement for safety net providers; reimbursement for out-patient services in hospitals; the support of the cost of medical residents who provide substantial amounts of care to Medicaid consumers; services to people with mental illness; the design of home and community based waiver programs for the elderly and people with physical and developmental disabilities; the facilitation of service access for adults and children with

the most complex medical, emotional and social services needs; and the ability of states to support school-based efforts to enroll needy children into Medicaid coverage. The proposed regulations represent a shift of billions of dollars in federal costs to states. The Administration has estimated that the full implementation of these regulations will produce $13 billion in reduced federal Medicaid spending over the next five years; states have estimated a considerably larger potential impact of these regulations, predicting losses as high as $50 billion in federal Medicaid support over the same period. Because most states do not have the resources to absorb these costs, there will be little choice but to restrict services for consumers.

HR 5613 would place seven of the proposed regulations under a moratorium until March 2009. (The eighth regulation regards the operation of the U.S. Health and Human Services' Departmental Appeals Board and, while not specifically associated with federal savings, is viewed by most states as seriously undermining the availability of due process for states through an administrative appeal before the federal department.) State Medicaid directors are strongly supportive of efforts to provide a "time out" on these regulations to allow a careful consideration of the impact of proposed policy changes on the vulnerable people served by states. Directors also encourage a more robust public debate on the merits of some of the proposed changes in such a critical program. It's important to note that some of the proposed regulations contain provisions that Congress rejected during debate over the DRA of 2005. In addition, because many of the regulations were issued either as interim final regulations or with significantly shortened comment periods (as few as 30 days), there has been inadequate opportunity for public

input on these proposals. As a result, these proposals appear to have unintended consequences on good programs and will limit legitimate services to vulnerable people.

States have heard the words "schemes" and "abuse" and even "fraud" when they've asked why these regulations are justified. We've been told that the extreme approach in some instances is the result of a firm intention to guarantee that there are no more "loopholes" that may allow states to draw more federal matching funds than the Administration believes is proper. I'd like to make two points regarding this justification.

First, I urge Congress to look beyond the words that incite outrage to consider the actual implications of proposed changes. NASMD has been clear in our interactions with CMS that we do not seek to defend inappropriate excesses in federal claiming. While Medicaid directors may sympathize with states that have responded to very real fiscal pressures by, in part, over-reaching in terms of the use of Medicaid funds to support otherwise under-funded programs, directors have not asked CMS to walk away from these issues. Rather, NASMD believes that CMS has, in most instances, already found strategies to successfully identify and remediate areas of clear excess. In recent years, CMS has put in place new informal or formal guidance on IGTs, CPEs, and school administrative claiming, just to name a few. At the Administration's urging, Congress has enacted reforms to targeted case management, clarifying important parameters regarding benefit design and how Medicaid interfaces with other public programs. Congress has authorized additional funding for CMS auditors, both to monitor state fiscal arrangements and to increase provider reviews. States would argue that CMS has, in fact,

already solved much if not all of the problems that were of legitimate concern regarding state claiming of federal reimbursement.

Second, the apparent focus of the regulations to assure that "no loopholes" remain has resulted in overly-broad changes and prohibitions that are throwing the figurative baby out with the bath water. For example, some school administrative claiming arrangements in the past may have charged excessive costs to Medicaid. However, a school nurse who works today to help a child with untreated medical needs enroll in the Medicaid program is not an abuse of the system. It is a critical component of an effective Medicaid program. But under the school services regulations, this legitimate activity would be prohibited from receiving Medicaid support.

It may be useful to clarify the definition of rehabilitative services. However, to declare an entire group of individuals to be ineligible for rehabilitation services because CMS has unilaterally decided that people with developmental disabilities cannot ever benefit from rehabilitation appears biased and of uncertain clinical merit.

It was certainly appropriate for CMS to reflect in rule the definition that Congress enacted to define case management as a comprehensive service. However, CMS's decision to reverse years of federal policy by now prohibiting the use of administrative case management, purportedly in order to avoid any "loophole," appears again to have been an over-reaction, well beyond what Congress enacted and with no regard for the

consequences for states which have now lost an important option for assuring the quality and effectiveness of services delivered to high cost populations.

NASMD urges Congress to support HR 5613, giving states, federal policy-makers, consumers and providers a period of time to understand and prevent the unintended consequences of these regulations, and to revisit and debate the wisdom of the apparently intended consequences as well. We need an opportunity to find the right balance between federal clarity and state flexibility, between absolute assurances that federal funds are never "over-used" and the imperative for states to be able to meet the needs of the elderly, children with special health care needs, and other persons with complex, chronic or disabling conditions. Finally, we need more realistic timeframes for implementation of new regulations, particularly for regulations that change existing federal policy as reflected in years of approved state plans.

Thank you for your interest in this issue. NASMD and its members stand ready to work with Congress and the Administration to resolve this important set of challenges. I look forward to your questions.